THE RHODE ISLAND DEPARTMENT OF HUMAN SERVICES

Dear Provider,

Thank you for your interest in the Rhode Island Medical Assistance Program. Enclosed are the forms and information necessary to enroll as a performing provider within an established group. Please send those that are marked mandatory for enrollment processing:

- Local Education Agency (LEA) Provider Linkage Form
- Current copy of your practice's form of licensure
- Provider Agreement and Addendums I & II

Completed enrollment forms should be mailed to:

EDS
Provider Enrollment Unit
PO Box 2010
Warwick, RI 02887-2010

If you have any questions about the enrollment form or enrollment process, please call EDS at **1-401-784-8100** for instate and long distance callers or 1-800-964-6211 for instate toll callers and border communities.

IMPORTANT NOTE: **Please DO NOT send any claims with your application.** Wait until you have received your provider number and a billing manual. If you are an out-of-state provider, wait for your provider number, manual and Prior Authorization before sending in any claims.

An incomplete application will be returned.

LEA Enrollment Instructions

The following fields must be completed:

PROVIDER NAME: Enter your individual or facility name.

SERVICE LOCATION ADDRESS: Enter the complete physical address where service is being conducted.

NATIONAL PROVIDER IDENTIFIER (**NPI**): Enter the NPI number established by CMS (Centers for Medicare/Medicaid. If your agency has been exempt from receiving an NPI, please attach a copy of a letter stating such.

TAXONOMY (**ies**) – Enter the Taxonomies established by CMS

PROVIDER TYPE/SPECIALTY: Indicate the specific service you provide. e.g., MD –Psychiatrist; Therapist – Social Worker, Psychologist, etc. (Disregard if you provided your NPI & Taxonomy/ies)

PROVIDER PHONE NUMBER: Enter the area code and telephone number of the location where service is being conducted.

LICENSE NUMBER: If your are required to be licensed to provide services, enter your license or certification number. A copy of the current valid license or certification letter must be submitted with the application.

NATIONAL PROVIDER IDENTIFIER (**NPI**): Enter the NPI number established by CMS (Centers for Medicare/Medicaid) for the School department you are joining .

TAXONOMY (**ies**): Enter the Taxonomies established by CMS for the School department you are joining.

SCHOOL DEPT. NAME: Enter the name of the school department.

SCHOOL DEPT GROUP MA PROVIDER NUMBER: Enter the provider number(s).

SCHOOL DEPT. TAX IDENTIFICATION NUMBER: Enter the Federal Employer Identification Number (FEIN).

SCHOOL DEPT PAY TO ADDRESS: Enter the address where you want checks and/or Remittance Advice(s) sent.

SCHOOL DEPT MAIL TO ADDRESS: Enter the address where all other program information should be sent.

EFFECTIVE DATE: Enter the date you will begin servicing the students.

FAX NUMBER – Enter the office fax number

EMAIL ADDRESS – Enter the office email address for the actual provider (doctor) to receive future correspondences via email

PROVIDER SIGNATURE AND DATE: Application must be signed by the Individual Applicant along with the date of signature. Stamped or photocopied signatures are not acceptable.

AUTHORIZED SIGNATURE OF SCHOOL DEPARTMENT REPRESENTATIVE, TITLE, AND DATE: A Representative from the School Department must sign and date the form to indicate that they wish to be affiliated with the provider listed on the application.

STATE OF RHODE ISLAND
DEPARTMENT OF HUMAN SERVICES
LOCAL EDUCATION AGENCY (LEA) PROVIDER LINKAGE FORM

Provider Name:_____

Service Location Address: _____

National Provider Identifier NPI:_____

Taxonomy (ies): _____

Provider Type/Specialty: (please circle) if other, please specify:
(Disregard if you provided your NPI & Taxonomy/ies)

OT PT Speech Social Worker

Psychiatrist RN Psychologist

Transportation Personal Care Attendant

Residential Placement Other _____

Provider Phone Number: _____

License #:_____

National Provider Identifier (NPI):_____
(School Dept. NPI)

Provider Taxonomy (ies):_____
(School Dept. Taxonomy/ies)

School Dept Name:_____

School Dept Group MA Provider Number:_____

School Dept Tax Identification Number: _____

School Dept Pay to Address:_____

School Dept Mail to Address:_____

Effective Date: *_____
Indicate the effective date when the Provider began providing services to the School Department

email address_____ **fax #**_____

_____
Provider Signature **Date**

_____
Authorized signature of School Department Representative **Title** **Date**

For EDS Use Only
Census Track:_____ **County Code:**_____
Town Code:_____ **Location Code:**_____

*****PLEASE FURNISH A COPY OF THE CURRENT LICENSE FOR PROVIDER MEMBER LISTED*****
RETURN FORM TO: EDS, PO BOX 2010, WARWICK, RI 02887-2010, ATTN: PROVIDER ENROLLMENT UNIT
Last Updated January 29, 2007